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The Future of ORL-HNS and Associated Specialties Series

Medicolegal and ethical aspects of ORL-HNS in the new millennium

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'All professions are conspiracies against the laity'
G.B. Shaw

The last three decades of the old millennium have seen enormous changes in surgical practice, in ethical concepts applied to medicine, in society's attitude to the professions (and medicine in particular), and in clinical negligence litigation. Here we shall explore the ways in which each of these areas may change and develop as we enter the new millennium, in particular from the standpoint of ENT/Head and Neck Surgery.

Medical and surgical practice

The achievements of medicine and surgery since the 1940s are almost the stuff of legend. In one disease after another, we have moved from a position of impotence to one of control. Within our own specialty, developments in ear surgery, cochlear implantation, endoscopic sinus surgery, phoniatrics, and ablation and reconstruction of head and neck cancers have been impressive. Yet there is an irony: expectations have outstripped achievements, and the reputation of the medical profession has suffered serious blows in the last 10 years. Doctors are now subject to almost as much media criticism as lawyers, and the threadbare accusation of paternalism is raised repeatedly against modern doctors, who are surely the least paternalistic of the last 100 years. There is a misunderstanding among the public of what the professions can achieve. Litigants go to law for justice, but justice is hard to define and depends on viewpoint: they receive the remedy the law can provide. Patients go to doctors for health, but the concept is as nebulous as justice: they receive medicine, whether preventative, curative or palliative. In a consumerist age, expectations are high and disappointment common. The resulting dissonance colours every discussion of the future of medical care.

The new millennium will witness many developments, including those derived from the human genome project. We shall see progress in cancer treatment, and probably in inner ear disease, otosclerosis and rhinosinusitis, resulting from genetic engineering. It will be expensive technology, and the rationing debate will worsen, and add to an intense ethical conflict between those who embrace gene therapy and those who oppose it. We have already seen the beginnings of such discussions in agriculture, and their foreshadowing in the debate about cochlear implantation for congenitally deaf children.

Clinical negligence litigation

In 20 years, the United Kingdom medical litigation climate has changed from the 'conspiracy of silence', with expert evidence of negligence hard to find, to a more open and balanced one. Investigations and actions now attract high quality expert evidence for claimants. Pretrial disclosure, subspecialization among solicitors, and the Woolf reforms (encouraging joint discussions and reports) have speeded actions. Few cases except those concerning genuinely difficult points now come to trial in the United Kingdom.

In the future, litigation cases will continue to increase, as a consequence of public suspicion (fuelled by the press) and an increasingly North American legal climate. We do not believe that legal aid restrictions will counter the increase, because insurance-based litigation and conditional fee arrangements are largely filling the gap.

New areas will develop, and some of these will be conditioned by the Human Rights Act, due to come into force on 2 October, 2000, which allows litigants to rely on European Convention rights in the United Kingdom. It will be unlawful for a public authority (which may be an NHS Trust or an individual hospital doctor or GP treating NHS patients) to act

in a way incompatible with a Convention right;[1] a non-complying public authority can be sued for damages.[2]

The legal concept of failure of informed consent will probably be affected. At present, UK law continues to recognize the Bolam test:[3] the doctor is not liable if he acted in accordance with a practice accepted at the time as proper by a reasonable or responsible body of medical opinion, notwithstanding that other doctors adopted different practices. It has been traditionally very difficult, although not impossible, to win cases in failure of informed consent for this reason. Article 8 of the Human Rights Act, however, gives the patient – as part of his right to respect for his private life – the right to make his own decision whether to undergo a course of treatment, and this entails the right to be informed of all material risks. This will be subject to 'therapeutic privilege', if the doctor can show that it was positively necessary not to inform the patient of a certain risk for the sake of the patient's health.[4] Article 8 may sound the death knell of the Bolam test in this and other areas – including diagnosis and treatment – where it has long held sway in the UK jurisdiction, although overturned elsewhere (e.g. Australia).

Article 2 of the Act provides that 'everyone's life will be protected by law . . .'. A public authority has a positive duty 'to make appropriate steps to safeguard the lives of those within its jurisdiction'. A patient denied lifesaving treatment through lack of funds or facilities may thus be able to sue an NHS Trust or Health Authority. An excellent potential example is provided by the long waiting times for commencement of curative radiotherapy for head and neck cancer – between eight and 12 weeks at present in the North West of England. This undoubtedly affects prognosis. Perhaps the law may achieve, in this context, what public and medical pressure have failed to deliver.

Litigation may also be possible when particular tests (perhaps expensive ones using new technology) have not been performed. Doctors may be in a cleft stick: not to test may lead to litigation, but over-testing (defensive medicine) may make them liable for injury resulting from the tests themselves.

It should be noted that the Act allows patients, but not doctors, to exercise their human rights.

Following from this, we shall probably see litigation arising from inadequate experience of high risk procedures (such as parotidectomy and stapedectomy, as well as head and neck cancer). Despite frequent warnings from subspecialists, this is an area that experts and the Courts have been reluctant to approach, partly, no doubt, because of the defence provided by the Bolam doctrine in the presence of widespread low-volume operating. If that doctrine is overturned as we anticipate, there will be no bar to cases, although definition of the minimum caseload will prove difficult in the absence of reliable evidence.

Finally, there will be increasing interest in risk management, a field in which surgery lags well behind aviation. Nerve monitoring is underused in UK head and neck surgery and otology, and computer-guided endoscopic sinus operating, which has the potential to abolish the occasional devastating consequences of modern sphenoethmoid surgery, even more so. The law has a proper and legitimate role in pressing for safer operating environments.

No fault compensation is frequently discussed, but we see no sign that it is supported at present by the British judiciary, let alone politicians. If developed, it could have the drawback of removing the element of proper liability for unsatisfactory care.

Doctors have tended to see litigation as unreasonable and the Courts as unfair, but we do not share that view. Bearing in mind their long experience in adjudicating on standards of care, we would see the Courts as more reliable, and less prone to political pressure, than the General Medical Council in its new role of monitoring professional performance.

Ethics

Immense changes have occurred in medical ethics in the 20th century. A complete reversal occurred after the introduction of the Abortion Act, and another has taken place among those who advocate euthanasia. These alterations reflect societal change and the secularizing of moral and ethical beliefs in the Western world. When the medical author of this article qualified, the General Medical Council stressed that doctors should not criticize colleagues ('The depreciation of the professional skill, knowledge, services or qualifications of another doctor or doctors may . . . lead to disciplinary proceedings').[5] Now, doctors are warned to watch colleagues for poor performance and report them.

This has followed the rise of consumerism, and a prevailing anti-professional ethos that, one suspects, has been encouraged by politicians of both major parties resentful of medical criticism of the quality of public services. All doctors who have followed the Bristol case will have learned that it is no longer acceptable to do one's best in the treatment of gravely life-threatening disease, if others can produce better results. This is a definite change in the profession's ethical base. It applies regardless of financial, administrative or organizational aspects of a particular service. Surgeons must also reflect that they can be removed from the medical register on conduct grounds if they give inadequate warnings of the risks of complex procedures in their own hands (the disciplinary issue in the Bristol case).

The retention of human tissue following post-mortem examinations (an unquestioned norm throughout the 20th century) has been challenged and overturned at the century's close, with serious training implications for otology. Finally, the Shipman case, which was one of serial murder, not of professional incompetence or negligence, has been lumped in with the other complex professional and technical issues to add to the pressure for scrutiny of doctors' results and outcomes.

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For the foreseeable future, trained doctors will walk a tightrope in which any professional failure is seen as a potential ethical or disciplinary issue, with risk of termination of career. The old ethic of loyalty to one's profession, its tradition of duty, its scientific basis and its improvement, will be replaced by a consumer-driven ethic of response to patients' wishes, ideas and (sometimes) demands. How far these last will be restrained by what is reasonable, rational or effective remains to be seen, but a tension with evidence-based medicine and necessary rationing of care is inevitable, and is being seen at the time of writing in connection with the National Institute for Clinical Excellence's decision on prescription of beta interferon for multiple sclerosis.

At present, a doctor is obliged to provide only such treatment as the practitioner recommends and sees as medically appropriate. Will this change in the 2000s? If so, what provision will there be for conscientious refusal to provide a given treatment – for example, to refuse palatoplasty to an antisocial snorer, on the grounds that, in the surgeon's opinion, the treatment is of doubtful efficacy and overly invasive in the context of what is being treated?

There are at present only two statutes that allow doctors to refuse treatment on the grounds of conscientious objection: the Human Fertilisation and Embryology Act, 1990, section 38, and the Abortion Act, 1967, section 4. Will treatment for dying be codified, and, if so, will the doctor be able or unable to follow the dictum of Solzhenitsyn: 'Let evil come into this world, but not through me' – one which many current practitioners might feel applies to the potential practice of physician-assisted suicide.

If the concept 'The patient is King' is fulfilled, it will end some of the old, unacceptable attitudes of the post-war period. It is not, however, a new notion. J.B. Murphy, who died in 1916, wrote: 'The patient is the centre of our medical universe around which all our works revolve and towards which all our efforts trend.' Many current doctors left medical school determined to put patients first, but have no wish to see the best traditions of science and duty replaced by capricious whim or wish.

Undoubtedly, the styles and standards of practice which the new millennium will enforce will take more time than has been traditionally available in the NHS. This will be of benefit to traditionally hard-pressed surgeons, but will reduce the 'efficiency' of the service, and may thus surprise politicians. The dichotomy of opposing pressures of numbers and standards will become clearer than ever before, and highlighted by intolerance of error in those doing their best under heavy demand. This pressure on the NHS will be reinforced by another, arising from the liability of all surgeons to be investigated throughout their careers, since adverse events will occur in every surgical practice and despite every precaution. Earlier burnout and retirement are surely inevitable, with loss of senior and experienced personnel as is already occurring.

Much of the data for effective monitoring and revalidation could be painlessly drawn from proper national statistics and audit of outcome, carried out by independent analysts attached to each surgical team, with results feeding into alteration of practice. This is what the public would expect clinical audit to mean, but there has never been any commitment within the NHS to such universal audit performed by objective personnel, nor has funding been forthcoming. If this essential change came now, revalidation would require little of the current tortuous discussion.

At some time in the new millennium, rationing will have to be addressed and faced squarely by politicians. They have none but themselves to blame if they tell the public that any and all treatment must be available through the NHS, but tell NHS managers and doctors that they must make endless efficiency savings. It seems unlikely that a comprehensive health care service for the United Kingdom can continue to be funded entirely from taxation, and we believe that some form of private-public partnership on the European model will develop sooner rather than later.

Conclusion

The whole medical profession has been through a challenging time in the closing years of the 20th century. It would be easy to become disillusioned, especially by the attentions of the mass media. We began with a quotation from Shaw, and shall allow ourselves one more in that context: '*When the wooden idol does not answer the peasant's prayer, he beats it: when the flesh and blood idol does not satisfy the civilized man, he cuts its head off.*'[6] Doctors, however, are not idols, but human beings with human limitations, doing their best to help those in trouble. Even those who have occupied the public pillory because of unsatisfactory performance or attitudes have, in all probability, done more good in their lives than those who have delighted in publicizing their failures and humiliation.

The new millennium offers to all who practise medicine many opportunities to come closer to those ideals which motivate them. If we grasp those opportunities, and insist on the time and facilities to bring them to reality, we shall see medicine grow and flourish as never before, and Hippocrates' long art mature into its finest evolution yet. Honest admission of our individual strengths and weaknesses, and willingness to share decisions and responsibilities with our colleagues, will not diminish us, but enhance our professional lives and achievements. We need not retreat into defensiveness, but we must ensure that our real (not imagined) capacities are recognized. We must also make clear, not by withdrawal but by forthright debate, that the human rights of doctors to uphold their proper ethical values and professional standards are respected alongside the vital rights and needs of patients, for these are in truth two sides of the same coin.

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